

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009612

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 19

FILED MAR 5 1962

1. PLACE OF DEATH

a. COUNTY SULLIVAN

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN POLK TWPLength of stay in 1b
50 YRSc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION SULLIVAN MEMORIAL HOSPITALInside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY SULLIVAN

c. CITY OR TOWN MILAN

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First Middle Last
WILLIAM ESTES FRAZER JR.

4. DATE OF DEATH

Month Day Year
FEB 26 1962

5. SEX

M

6. COLOR OR RACE

W

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

2-11-77

9. AGE (last birthday)

85

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER - RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

SULLIVAN CO

12. CITIZEN OF WHAT COUNTRY

U.S.A

13a. FATHER'S NAME

BENJAMIN FRAZER

13b. MOTHER'S MAIDEN NAME

MARTHA HULL

14. NAME OF HUSBAND OR WIFE

MAGGIE FRAZER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

CLIFFORD FRAZER

Address

MILAN MO

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

2 days

DUE TO (b)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN OR LOCATION

COUNTY

STATE

21. I attended the deceased from

JAN 1975 to

FEB 26, 1962 and last saw him alive on

FEB 26, 1962

Death occurred at

6405

a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

1 1050

2 1050

3

4 0

5 2

6

7 0

8 2

9 331X

10

11

12 1-0

13 2-0

APR 26 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Russell L. Ligon*

Licensed Embalmer No. 3792

P. O. Address *Melrose Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.